Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	005023	A. BUILDING _____ B. WING _____	03/26/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLIAM N WISHARD MEMORIAL HOSPITAL	1001 W 10TH ST INDIANAPOLIS, IN 46202

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS This is a State hospital complaint investigation. Complaint: # IN00103736 Unsubstantiated: Lack of sufficient evidence. Dates of Survey: 3/26/2012 Facility Number: 005023 Surveyor: Albert Daeger, Medical Surveyor William N. Wishard Memorial Hospital is in compliance with 410 IAC 15-1.5-2, Infection control and 410 IAC 15-1.5-8. Physical plant, maintenance, and environmental services. QA: claughlin 05/02/12	S 000		